FILED NOV 10 1943
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 34366

Registration District No. 53 — Primary Registration District No. 3010 — Registrar's No. 331

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County: Cape Girardeau
(b) City or town: Cape Girardeau (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Southeast Missouri
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 7 days (Specify whether years, months or days)
In this community 7 days

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: New Madrid
(c) City or town: Matthews Mo. (If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME: Pauline Carter
3. (b) If veteran, name war: x
3. (c) Social Security No.: x

4. Sex: F
5. Color or race: W
6. (a) Single, widowed, married, divorced: M
6. (b) Name of husband or wife: J.E.Carter
6. (c) Age of husband or wife if alive: — years
7. Birth date of deceased: 8 (Month) 25 (Day) 1906 (Year)

8. AGE: Years 37, Months 1, Days 25. If less than one day ___ hr. ___ min.

9. Birthplace: Lepanto (City, town, or county) Ark. (State or foreign country)
10. Usual occupation: Housework
11. Industry or business:

FATHER
12. Name: Luther Coleman
13. Birthplace: Jonesboro (City, town, or county) Ark. (State or foreign country)

MOTHER
14. Maiden name: Dove Thompson
15. Birthplace: Harrisburg (City, town, or county) Ark. (State or foreign country)

16. (a) Informant: John Earl Carter
(b) Address: Matthews Mo. R.F.D.# 2
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/23/43 (Month) (Day) (Year)
(c) Place: burial or cremation: Morrilton Ark.
18. (a) Signature of funeral director: H.W.Albritton
(b) Address: Sikeston Mo.
19. (a) 10-29-43 (Date received local registrar) (b) F.K. Phelps (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 day 20 year 1943 hour 3 minute a M.

21. I hereby certify that I attended the deceased from 10-18, 1943 to 10-20, 1943
that I last saw her alive on 10/20, 1943
and that death occurred on the date and hour stated above.

Immediate cause of death: Brain Abscess — Duration:
Due to: ?
Due to: ?
Other conditions: (Include pregnancy within 3 months of death) [illegible]
Major findings:
Of operations
Of autopsy

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

23. Signature: [illegible] (M.D. or other) M.D.
Address: Cape Girardeau Mo. Date signed: 10/22/43

1014

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 4

District File Number 1143-29

Date Filed 11-8-48

JUN 8 1949

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

Embalmed, Registered Apprentice No.....

working under my personal supervision.

Signed Hunter Allcutton

Licensed Embalmer No. 4210

P. O. Address Sikeston Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

Form No. 2B
7-43
I X36930

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 20 JUV

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Cape Girardeau

(b) City or town Cape " " (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: S. E. Mo. Hosp.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 da. (Specify whether years, months or days)
In this community 7 da.

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____

(c) City or town _____ (If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME Pauline Carter

3. (b) If veteran, name war —

3. (c) Social Security No. —

4. Sex F | 5. Color or race W | 6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased 8 (Month) 23 (Day) 06 (Year)

8. AGE: Years 37 | Months 1 | Days _____ | If less than one day _____ hr. _____ min.

9. Birthplace Ark. (City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

FATHER
12. Name _____
13. Birthplace _____ (City, town, or county) _____ (State or foreign country)

MOTHER
14. Maiden name _____
15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____
(b) Address _____

17. (a) _____ (Burial, cremation, or removal) (b) Date thereof _____ (Month) (Day) (Year)
(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____
(b) Address _____

19. (a) _____ (Date received local registrar) (b) _____ (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. 10
year 1943 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19__ to _____, 19__; that I last saw h_____ alive on _____, 19__; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Brain abscesses (Surgical)	
Due to Mast.	
Due to _____	
Other conditions None (Include pregnancy within 3 months of death)	

Major findings:
Of operations _____
Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____
While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature _____ (M. D. or other)
Address _____ Date signed 11/1/43

SUPPLEMENTARY

MO

343666